# Morris View Healthcare Center
## Pre-Admission Information – Implantable Devices

*The following information is important for continuity of care and functional maintenance of implantable devices. This information is also required when a resident needs an MRI, CT Scan, Mammogram, etc. Please complete as much information as available.*

| | |
|---|---|
| Name: _____<br><br>Family/Friend completing this form: _____<br>Phone Number: _____ | Date:<br>_____ |

| | |
|---|---|
| **LENS**<br>Eye: ☐ Right ☐ Left ☐ Both<br>Implant date: _____<br>Last eye exam date: _____ | Physician (Implanted): |
| **PACEMAKER**<br>Implant date: _____<br>Make: _____ Model Number: _____<br>Last date checked via phone: _____<br>Last date checked at pacemaker clinic: _____ | Physician (Implanted): |
| **INTERNAL CARDIAC DEFIBRILLATOR**<br>Implant date: _____<br>Make: _____ Model Number: _____<br>Last date checked: _____<br>Where was it checked? _____ | Physician (Implanted): |
| **INTRATHECAL PUMP eg. Baclofen**<br>Implant date: _____<br>Last date checked and refilled: _____<br>Name, address & phone of company or group refilling pumps: | Physician (Implanted): |
| **HIP REPLACEMENT(S)**<br>Hip: ☐ Right ☐ Left ☐ Both<br>Implant date(s): _____ | Physician (Implanted): |
| **KNEE REPLACEMENT(S)**<br>Knee: ☐ Right ☐ Left ☐ Both<br>Implant date(s): _____ | Physician (Implanted): |
| **INTERCEREBRAL CLIPS – eg. Vascular clip(s)**<br>Implant date: _____<br>Location of: _____ | Physician (Implanted): |
| **PORT-A-CATH**<br>Insertion date: _____ | Physician (Inserting): |
| **PEG or FEEDING TUBES**<br>Size: _____<br>Insertion date: _____ | Physician (Inserting): |

| | |
|---|---|
| **INSULIN PUMP**<br>Implant date: _____<br>Date last checked and refilled: _____ | Physician (Implanting): |
| **EAR IMPLANT eg. Cochlear implant**<br>Ear: ☐ Right ☐ Left ☐ Both<br>Implant date: _____ | Physician (Implanting) |
| **ARTIFICIAL HEART VALVE**<br>Implant date: _____ | Physician (Implanting) |
| **SHUNT**<br>Location: _____<br>Implant date: _____ | Physician (Implanting) |
| **PENILE PROSTHESIS**<br>Implant date: _____ | Physician (Implanting) |
| **PESSORY, IUD, DIAPHRAM**<br>Insertion date: _____ | Physician (Inserting) |
| **BREAST IMPLANT**<br>Location: ☐ Right ☐ Left ☐ Both<br>Implant date: _____ | Physician (Implanting) |

*Please check if appropriate:*

☐ Medication patches
☐ Magnetic implant
☐ Latex Allergy
☐ Body Piercing
☐ Artificial limb
☐ Bullets, Shrapnel, BBs
☐ Coil, Filter or Wire in blood vessel
☐ False teeth, retainers, tooth implants

**Print Form**